ISSUE BRIEF

Homemaker Services – Workforce Issues

May 30, 2008

Metropolitan Social Services
Planning & Coordination Unit
Lee Stewart, Adult/Senior Coordinator

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Introduction

This issue brief explores elements of the in-home Homemaker workforce in public and private employers. Labor statistics sources refer to this type of work as Home Care Aide or Personal Care Assistant. The term Homemakers will be used in this report for these classifications of workers providing services in the customer's home, unless otherwise stated.

The key points in this issue brief are the following:

Quality and consistency of customer care increases if Homemakers...

- Are full-time employees with wages above the area average for that job
- Receive health and other benefits/reimbursements
- Are provided adequate training, supervision and opportunities for advancement

A review of available data leads to the conclusion that these elements are more readily found in public and non-profit entities employing Homemakers than in private for-profit agencies.

The need for this service and other in-home services will increase for decades as the population ages, regardless of technology advances, and consumers will have more choice and voice in their care resulting in a more competitive marketplace.

Overview of the Homemaker Job

History

From the first hospital reported in history at about 300-400 BC to the Second world War, hospital treatment was primarily for the poor and dying. It appears that the first organized provision of Home Care in western countries appeared during Crusades. Generally, hospitals were designed for the poor and dying, especially those with infectious diseases.[1]

The U. S. is the country with the longest tradition in home care provision. In the late 1800s in the United States, most nurses worked in homes, helping new mothers and treating people with infectious diseases. The demand for this in-home care continued to grow, and non-profit (charity) organizations began to offer these services. Over 550 of such organizations employed over 1,400 nurses by 1909. It was around this time that insurance company Metropolitan Life began offering nursing services to policyholders, and the American Red Cross started a visiting nurse program in rural areas. Local Red Cross chapters began offering this service after World War I. By 1930, chronic degenerative diseases and not infectious diseases were leading causes of death, and people of all economic levels began seeking hospital care. In the 1950s, home care declined, but started growing again in the late 50s as hospital costs rose and nursing organizations advocated for it. Medicare's enactment in 1985 accelerated the industry's growth by covering home health care services for the elderly. Medicaid enactment followed. This the state-operated medical assistance program for the poor included provisions for home care.[2]

In 1985 a lawsuit against then-Health Care Financing Administration (HCFA) resulted in a re-write of the Medicare coverage policies and significantly increased Medicare's annual home care outlays, and the number of home-care agencies rose to over 10,000. [3]

Job Requirements

Some of these workers perform a variety of tasks which provide enough help to allow elderly and disabled customers to stay in their own homes and apartments in the community, delaying the need for more expensive institutionalization. Other Homemakers help low-income families by teaching home maintenance skills such as preparing healthy meals on a budget, budgeting and balancing a checkbook, child rearing best practices, etc. The kinds of tasks they do for each person or family is determined by a needs assessment. Homemakers also provide monitoring of the customer's well-being through observation at visits.

Example Tasks

- Most customers need help with Activities of Daily Living, such as basic house-cleaning, making beds, doing laundry, and washing dishes
- Some customers need help with non-medical personal care, such as personal hygiene/bathing assistance, including in-bed bathing
- Homemakers must document what they do, and maintain records of customer progress, reporting changes in client condition to a manager or supervisor
- For some customers, Homemakers instruct and advise issues such as maintaining household cleanliness, utilities conservation, hygiene, nutrition and infant care, so they can learn to maintain the home on their own, and no longer need assistance.

Knowledge

In addition to knowing how to do the homemaking tasks above, Homemakers must be able to interact with all kinds of people who have all kinds of personalities. Homemakers must know and use basic principles of good customer service.

Rationale for Home Care

The cost-effectiveness of home care is well-documented. Much research has shown it to be a cost-effective service for individuals recuperating from a hospital stay and for those who, because of a functional or cognitive disability, are unable to take care of themselves. Examples of such research includes patients with COPD, terminally ill veterans, psychiatric care patients, and patients with congestive heart failure. However, there are other reasons for home care, in addition to it's cost-effectiveness. Care at home supports the care provided by family members and friends, maintains the recipient's dignity and independence, and allows patients to take an active role in their care.[4]

Tennessee has one of the highest rates of disability (22%) in the nation – The national average is 19.3% for the population of people 5 and older.[5]

Overview of Homemaker Providers – Homemaker providers can be divided into three groups:

Governmental — In Davidson County, Metro Social Services is the only significant governmental provider.

Non-Profit Providers — There are only a few non-profit providers serving Davidson County, such as Senior Citizens, Inc., and the Mid-Cumberland Human Resource Agency (Note that the MCHRA provides homemaking in the Davidson County under contract with Metro Social Services). These agencies receive funding from grants, foundations, contributions and

government contracts, and serve vulnerable residents, such as low-income people who are elderly or disabled, according to their various agency missions.

For-Profit (Private Industry) Providers – There are numerous for-profit businesses which provide homemaking to any paying customer, and to government-contracted customers. Unless they serve customers under government contracts, they do not have all the regulations required of government or non-profit agencies. As of May, 2008, seventeen (17) of these for-profit providers contract with the Greater Nashville Area Agency on Aging and TennCare to provide services to low-income elderly and disabled residents, and are licensed by the State and required to follow written state regulations. (A list of the for-profit agencies which contract with the State is available on the web at http://www.state.tn.us/comaging/SWWDAVIDSON.pdf).

Overview of Homemaker Demographics

In 2006, the total paraprofessional direct care workforce in both the health and long-term care sectors was made up of the following: [6]

- 1,391,430 nurse aides, orderlies and attendants, largely employed in nursing homes;
- 663,280 home health aides, a slight majority of whom work in home-based care settings;
- 566,860 personal care and Homemakers, two-thirds of whom work in home-based services [Calculating the number of home-based homemakers at 66% gives a total of 374,127 in-home Homemakers for 2006]

Women were about 90% of this paraprofessional workforce, and about 50% were racial or ethnic minorities (including 33% African American, 15% Hispanic or other persons of color). Homemakers working for home care agencies were more likely than nursing home staff to be foreign born and less likely to be U.S. citizens. This could indicate that in-home care jobs are entry-level positions for new immigrants. Home care workers were less likely to be married.

In-home workers were also older, (average age of 46, compared to 36 for nursing home workers). In fact, home care workers over age 65 were three times the number of direct care workers in nursing homes.

Only about a third of home care workers were employed full-time.

Homemaker Wages and Benefits

In 2007, there were an estimated 2,230 Home Care Aides in the Nashville-Davidson-Murfreesboro Metropolitan Statistical Area.[7] Data are available for Tennessee for the distribution of Homemakers between private and government agencies in 2007:[8]

Private TN companies:
9,600 home care aides employed — Mean hourly wage = $8.73

Public TN agencies (State plus Local)
210 home care aides employed — Mean hourly wage = $9.62

Because of the generally low wages and prevalence of part-time jobs, 19% of homemakers are poor, according to the 2000 census. Approximately one-third receive food stamps. More than two out of five homemakers lack health insurance coverage. Although 66% of Americans under age 65 have employer-based health coverage, only 34% of homemakers have health coverage through their job.[9]

As the chart below shows, wages for this occupation are low nationwide, and Tennessee home care aide wages are even lower and lag behind the national average.[10]

Average wages for Personal and Home Care Aides/Homemakers in 2007 were about the same as for 2006.[11]

Tennessee	$17,136 per year	$8.24 per hour
Davidson County	$18, 835 per year	$9.05 per hour

In 2000, the occupational distribution of Homemakers was as follows:[12]

Personal & Home Care Aides by Industry Group, 2000:

Occupational Category:	Home Health Care	Nursing/Personal Care	Residential Care	Other
	30.8%	3.5%	24.1%	41.6%

Benefits

Benefits data are not available by State or occupation, but general data are available geographically and by type of employer, as shown below[13]. In our region of the U.S. 60 – 68% of private firms offer healthcare benefits, generally less than the percentage of governments providing these benefits:

Establishments offering healthcare benefits: Private industry, March 2007: [14]

Characteristics	Healthcare benefits (may include a medical plan, or a separate dental, vision, or prescription drug plan)
All Establishments	60%
Establishment characteristics	
Service providing	60
1 to 99 workers	59
100 workers or more	93
Geographic areas	
Metropolitan areas	63
East South Central	68

For all occupational types, the benefits provided by government and private industry in 2007 are as follows:[15]

Government:	
Retirement benefits available to	89% of employees
Medical benefits available to	87% of employees
Private Industry:	
Retirement benefits available to	61% of employees
Medical benefits available to	71% of employees

Job Turnover

A 2004 study by the Health Resources and Services Administration indicated nationwide high turnover in Homemaker and similar occupations, often due job dissatisfaction resulting from the following: [15]

- Jobs are physically and emotionally demanding. They suffer injuries such as back problems resulting from lifting or transferring residents, and there is often pressure to "speed up" resulting in increased job stress
- Wages and benefits are generally not competitive with other available jobs
- Jobs are often not well designed or supervised, with few or no opportunities for advancement. Workers perceive a general lack of respect from management."

Agencies which provide reasonable work schedules, competitive wages, health and other benefits, training and good supervision can lessen these high turnover rates.

The relatively low skill requirements, low pay, and high physical and emotional demands of the work result in high job turnover. For these same reasons, many people are reluctant to seek jobs in the occupation.[16]

Turnover data for private firms are limited. For all Healthcare and Social Assistance occupations for private firms in Davidson County for the 2nd quarter of 2007, the employee turnover rate averages about 14%, as shown below:[17]

	14-18	19-21	22-24	25-34	35-44	45-54	55-64	65-99	All Ages
Female	29.90%	27.70%	22.00%	17.00%	14.70%	13.80%	13.00%	13.30%	15.40%
Male	28.00%	22.50%	20.00%	16.10%	11.80%	10.80%	9.80%	9.20%	12.70%

Homemaker Job Growth[18]

This situation is due mostly to the rise in the number of elderly people, with mounting health problems and who will need some assistance with daily activities. Older people and people with disabilities increasingly rely on and want home care.

Employment of personal and home care aides is projected to grow by 51% nationwide between 2006 and 2016...much faster than the average for all occupations. It is expected to grow by 27% in Tennessee by the year 2016. By 2014, there will be as many as 16,070 Home Care Aides in Tennessee, representing an annual average growth rate of 2.5 percent, faster than the 1.5 percent growth rate for all occupations in Tennessee. Growth plus replacement needs for Personal and

Home Care Aides in Tennessee are estimated to average about 550 openings per year from 2004-2014. Of these estimated 550 openings per year, 62.7 percent are due to growth (new positions) and 36.4 percent are due to replacements of workers leaving this occupation. (TN. Department of Labor – The Source: Narrative Occupational Summary, http://www.sourcetn.org/occprofiledata.asp?session=occdetail&geo=4701000000

Homemaker Workforce Shortage[19, 20]

The Emerging Care Gap: Between now and 2015 the "old-old", aged 85 and older (who are most likely to require long-term care) will increase by 40%. At the same time, the workforce of both paid and informal caregivers will not increase at all. The aging of America will speed up after 2015 and will continue to do so until 2050. The Bureau of Labor Statistics predicts a 45% increase in demand for long-term care by 2010. This would require about 800,000 new jobs for nurse aides, home care personnel and personal care. The increase in demand will be greatest in home care settings.

Change from Institutional Care to Community-Based Care: The number of older adults in nursing homes is declining, due to rapidly emerging community alternatives, including in-home supportive services. More in-home workers will be needed.

Disability Rates Declining: Disability rates among younger adults is declining, which may reduce the demand for long-term care services. However, the number of older people with disabilities is expected to dramatically increase, increasing the demand for services.

Baby Boomers are Different: Baby Boomer elders will look different than past elderly groups, being more racially diverse, more likely to be high school and college graduates, and more likely to have higher incomes. They will demand more choices and better quality.

New Models of Care for All: The long-term care system of the future will be different - Traditional nursing homes may disappear. Most services will be delivered in home and community-based settings, and there will be more consumer-directed care, increasing competition. Consumer-directed care allows people to make decisions about the services they want, who delivers the services and how and when they are delivered. Studies indicate that consumer-directed services are more cost-effective and that consumers like them better.

New Technology: New electronic ways of record-keeping, transmitting those records, and delivering and monitoring services, along with the consumer-directed nature of future services, may reduce the need for administrative support personnel, but not for direct-care workers.

Immigration Policy: Labor growth between 2000 and 2020 will be dominated by foreign-born people and people Baby Boomers aged 55 and over. Immigrants in particular are a growing force in homemaker services. They may be more willing than U.S.-born natives to work in caregiving occupations with lower wages. Immigration policies will affect the availability of this workforce.

Privatization of Social Services

Since the 1990s, state government agencies in the U. S. have been increasing their privatization of social services. A 1997 survey by the Council of State Governments found that social services departments were the most likely to report increasing privatization over time. Seventy-five percent reported that they planned to increase privatization in the next five years. A majority of

respondents reported they expect cost savings to take on greater importance in the future, although 76% reported only modest savings at the time of the survey (5 – 15%).
Welfare services privatization grew substantially after passage of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act. TANF services and child care are the social services most often contracted with private vendors. [21]

The belief that privatization will result in higher quality services coupled with an increasing dissatisfaction with the quality of public services provided momentum. Belief that the competitive marketplace will drive low-quality providers out of business contributes to support for privatization.[22]

Although privatization offers increased efficiency and flexibility in social service delivery, there are challenges that must be faced by governments to make such contracting-out successful. A Mathematica review of the literature summarizes seven challenges[22]

- Guaranteeing a competitive bidding environment
- Developing effective requests for proposals and contracts
- Monitoring contractor performance
- Addressing political opposition, *e.g.* from employee groups
- Involving community-based organizations, which may have difficulty competing with for-profit vendors
- Avoiding *brain drain*, the loss of knowledgeable government employees to private contractors, and
- Protecting the integrity of the procurement process, which depends on a good governmental bidding/selection process.

> Local governments outsourcing of social services basically takes two forms. The first is contracting with private providers to deliver single components of a larger program (*e.g.* job training for TANF recipients). The second is contracting out a complete program (*e.g.* a complete TANF program, with intake, assessment, eligibility, case management, *etc.).*[xx]

Summary

- Home Care, including Homemaking is a cost-effective way to delay or reduce institutionalization, and is increasingly desired and used
- Homemakers in the U. S. are generally women, mostly part-time, increasingly foreign-born, 50% minority, with an average age of 46
- Wages: This occupation generally offers low wages for mostly part-time jobs – Public entities pay more than private entities, partially by providing full-time jobs
- Benefits: Part-time workers (2/3 of workforce) receive no benefits – Public employers more often provide benefits than do private employers (87% *vs.* 71%)
- Job Turnover: It appears that there is greater turnover in private agencies due to lack of full-time work, lack of benefits, and lack of training & advancement opportunities
- There is an increasing need for in-home direct care workers which will continue for several decades. It will be necessary to increase salary and benefits for this occupation to reduce current high rates of job turnover in the private sector, and to fill the increasing number of jobs available industry-wide. Pubic and non-profit entities will feel increasing pressure to make services more cost-effective.

- More consumer-directed care options will increase competition and increase pressure to raise the level of service quality in the marketplace – Consumers will "shop around" for services and demand added value for their healthcare dollars.
- New technologies may reduce the need for record-keeping administrative personnel, but will not reduce the need for trained in-home workers.
- Privatization of social services, particularly welfare and child welfare services, is increasingly used by state and local governments. There are specific challenges that must be addressed for this to be successful. If implemented and monitored properly, cost savings and consumer satisfaction can be achieved.

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